DATE				REF	REFERRAL NUMBER: (HCS USE ONLY)									
PERSON BEING REFERRED (LAST, FIRST, MI)					DOB			D	CN	RACE		S	SEX	
ADDRESS (STREET, CITY, ZIP)					COUNTY			1		PHONE NUMBER(S)				
NAME OF PERSON MAKING REFERRAL					RELATIONSHIP						PHONE NUMBER(S)			
NAME OF R	REFERRING AGENCY								REFERRAL		_			
									Services Ro er-Directed Serv				ΠHD	М
IS THE II	NDIVIDUAL RECEIVING H	OME A	ND CC	OMMUNITY E	BASED	SERVI								
MEDICA	AID STATUS	Act		☐ Applied		Spendo	down		Not Eligible			HCB Eligib	ole	
	HEARING		sses	☐ Visually	Impair	ed _	] Blind		Hearing Aid	□ Не	earing Im	npaired [	_ De	af
	ARRANGEMENTS ANI	D MAF	RO			ADDRE						PHONE		
OTHER PER	RSONS INVOLVED			nysician		ADDRE	:55					PHONE		
LIST ALL DIAGNOSES LIST				nysician										
			-	ontact										
				ther (identify	<i>(</i> )									
(should cindicate i	correlate with meds.,		(OR A		LIST C				(RX and OTC) frequency)	FOR	DIAGNO	OSES		
NURSE PRELIM LOC							REQUIRED EXPLANATION – include how need is/was being met, who is/was meeting the need, and why help is now needed. Attach additional pages if						-	
	MONITORING  ☐ 0 (PRN medical check) ☐ 3 (medical check 1 x mo; stable) ☐ 6 (verified unstable medical condition) ☐ 9 (intensive, continuous monitorin ☐ Sees physician? ☐ Receives home health or hospice?				onitoring	)	Include medical condition and frequency							
	MEDICATION  ☐ 0 (No Rx Meds) ☐ 3 (Rx☐ 6 (Set-ups/supervision requ☐ Medication managemed ☐ Complex drug regimed dosages/time of admir	uired) ent need (i.e., m	<b>9</b> (Com ds to be ultiple p	nplex/ total assiste supervised?	with vari			Inc	dicate type of su	pervisio	on neede	d and how o	ften	
	TREATMENT  0 (none) 3 (simple d 6 (daily dressings – ulcers, days) 9 (dressing changes  Bowel Program Ca	ressings cath. or – more t	supposit ostomy c nan 1 x d	itories, care, PRN oxyge ly., new/unregul	en i.e.,use ated osto	ed within	last 30 . oxygen)	Inc	clude type of and	d freque	ency of tre	eatment		
RESTORATIVE  0 (No services) 3 (maintain current level) 6 (restore h 9 (intense teaching/training services to restore to higher level) Receives restorative (teaching/training) services?				higher funct. level) l)			Are services to maintain a current function, or restore the participant to a higher level of functioning				ioning	J		

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NURSE PRELIM LOC	PERSON BEING REFERRED (LAST, FIRST, MI)		REFERRAL NUMBER	HCS VERIFIED LOC							
	REHABILITATION  ☐ 0 (none) ☐ 3 (1 x wk) ☐ 6 (2-3 x wk) ☐ 9 (4 or more x wk)  Receives physician-ordered therapy?  ☐ PT ☐ OT ☐ ST ☐ Audiology		Indicate where s	ervices are provided and frequency							
	PERSONAL CARE		Indicate the amo								
	□ 0 (none) □ 3 (min. assist need, infrequent incont. – 1 x wk or less	s)	required								
	☐ 6 (moderate assist needed, frequent incont. – 2 to 3 x wk)										
	<ul><li> ☐ 9 (max. assist needed; continuous incont.)</li><li> ☐ Grooming ☐ Bathing/Equipment ☐ Toileting</li></ul>										
	DIETARY		Indicate type of	prescribed diet and amount of assistance							
	□ 0 (no assist) □ 3 (minimal assist w/ cooking/eating, special diet)		needed	presentate and amount of assistance							
	☐ 6 (mod assist by others) ☐ 9 (max assist/tube feeding)										
	Prescribed Calculated Diet Meal Preparation Needed	l									
	☐ Assist w/eating ☐ Tube Feeding  MOBILITY		La Pasta tona an								
	■ 0 (no human assist) ■ 3 (periodic human assist)			d duration of human assistance needed e device needed, architectural barriers							
	☐ 6 (direct human assist for ambulation) ☐ 9 (immobile)										
	☐ Human Assistance ☐ Turning/Positioning ☐ Assistive I	Device									
	BEHAVIORAL INFORMATION & MENTAL STATUS		Indicate type and	d amount of human assistance needed							
	☐ 0 (no assistance needed) ☐ 3 (periodic human assist) ☐ 6 (moderate human assist) ☐ 9 (maximum human assist)										
	☐ Wanders ☐ MI/MR/DD ☐ Combative				ļ						
	☐ Withdrawn ☐ Depression ☐ Disoriented										
	☐ Alert / Oriented ☐ Thinks clearly ☐ Dementia										
NURSE PRELIM	☐ Lethargic ☐ Memory deficits ☐ Suspicious /	Paranoid			HCS VERIFIED						
LOC TOTAL	☐ Supervised for safety				LOC TOTAL						
	☐ Able to make appropriate independent decisions										
	☐ Guardian ☐ Conservator ☐ Power of Attorney ☐ Pay	/ee									
	Needs assistance with the following: (indi			ed and who is currently helping)							
Laund	lry	☐ Gather/Take out trash									
☐ Vacuu	um/Dust	☐ Shopping Assistance									
☐ Clean	Bathroom	☐ Transportation									
☐ Clean	Kitchen	☐ Assist w/ Handling Money									
☐ Make	/Change bed	☐ Assist w/Telephone									
	Safety	//Emerger	ncy Plan								
Histo	ry of violent behavior	Priority Ris	Priority Risk: ☐ 1 High ☐ 2 Medium ☐ 3 Low								
☐ Weap	oons in the home	☐ Emerge	] Emergency Back-up Plan:								
☐ Viciou	us dogs										
☐ Other	s available in the home for support										
DIRECT	ONS TO LOCATE - COMMENTS:										
NURSE											
	SIGNATURE			DATE							
SUPER\	SIGNATURE /ISORY NURSE / PHYSICIAN SIGNATURE			DATE							